FAQs – HSCRC Transformation Implementation Program RFP

Q: How are the permanent rate increases going to work?

A: We expect that whatever is awarded would be expended through the end of the calendar year 2016. The amount awarded would be continued in rates indefinitely but the Commission will reserve the right to make adjustments in future years if funds are not being used as intended or initiatives fail to meet expected goals. For the regional planning grants, the award amount was included in rates for one year and will then be removed in following years. The implementations grants will not be removed (barring any adjustments made by Commission staff if expectations are not met) and will be in hospitals' rate bases and global budgets permanently.

Q: For the Regional Partnerships, what are the expectations about how the hospitals will share the funds?

A: Hospitals will need to submit the details in the budget about how the money would be shared. While distributions may change in future years, the partnership must demonstrate continued appropriate collaboration and sharing of resources.

Q: Can the RFP be used in lieu of the final Regional Partnership Transformation plan due Dec. 1?

A: No, both will need to be submitted, however, the RFP should reference and use information from the Regional Partnership Transformation plan in the RFP. We are attempting to reduce the burden of the multiple reports for the Regional Partnership grantees by incorporating those final reports into a same or similar template as the Strategic Transformation Plans.

Q: On one slide a discussion point was the understanding and working with social resources. Are you considering in the RFP awards that all counties are not provided the same state dollars for the health departments? These health departments are lacking equivalent social programs that our Partnerships have to provide, which can be costly. Shouldn't local Health Departments be budgeted in a like manners throughout Maryland and not use our GBR?

A: While this question goes beyond the scope of this RFP, the review committee will be considering proposals on the extent to which they can reduce avoidable utilization, reduce costs, and increase quality. Where there is a void in care coordination which results in an increase in the use of inpatient services particularly for chronic illnesses, there may be opportunity.

Q: If we are not meeting our goals and proposed outcomes would the rates be adjusted back down?

A: If this happens we anticipate having individual conversations with that hospital or partnership to try and help them meet their goals. However, if over time the hospital is still not meeting their goals and proposed outcomes, HSCRC reserves the right to make rate adjustments accordingly.

Q: Does the proposal need to be in the exact order as laid out in the RFP? Do the headings need to be the exact same?

A: Yes, please follow the format detailed in the RFP.

Q: Can you be more specific about the expectations for apportioning of ROI to Payers?

A: Under global budgets, most of the financial benefits of reduced utilization will accrue to the hospital. The clear expectation is that those resources would be shared among the partners identified in a proposal. Under this scenario, the public is directly benefited on two of the three pillars of the Three-Part Aim - better care and better health. In terms of reduced costs, the overall system (payers, patients, etc.) benefit by a reduction in the historical growth of hospital revenue in the State. Under global budgets however, patients and payers on a per-case basis may pay more as utilization is reduced. The Commission has specifically directed staff to ensure that there are savings to the Payers as a result of awards being made through this RFP. The most direct way to do that for all-payers is through an overall reduction in a hospital's global budget. However, more targeted approaches may be considered. A reduced cost in uncompensated care attributable to a proposed model, for example, would represent a payer savings.

Q: How do you advise we predict ROI for years beyond 2017 when implementation will not start until 2016?

A: The Commission expects a continued ROI into the future, especially since the dollars are permanently in rates. This should be explained in your plan for sustainability.

Q: Explain what you mean by reasonable ROI?

A: The Evaluation Committee will define what reasonable ROI is after reviewing the proposals. A base level ROI would be one that would sustain the initiative.

Q: References to assuring that the scope of the application complements but does not duplicate state and regional programs and resources. Could you please provide further clarification / reference material?

A: The Care Coordination Work Group report identified the role of state-wide infrastructure to support hospitals, providers, and other partners as they work toward improving care coordination. It is important that these initiatives do not duplicate the efforts that are being taken to support the infrastructure through CRISP and other means. It would not be prudent for all hospitals to build separate infrastructure and tools if they are available to all providers on a statewide level. Moreover, if there is funding currently available for a proposed initiative, it is not intended for rate dollars to supplant that resource.

Q: Can you further clarify the budget line items (explain what is permitted or not permitted in indirect costs for example)?

A: Indirect costs are those for activities or services that benefit more than one project and primarily a project that is not named in the proposal. Indirect costs could include costs related to administrative services that are budgeted under another function of the hospital or unit working on this initiative. Indirect costs may be listed in broad categories (overhead, shared administrative staff, etc), and for each category the applicant may include a percentage of the proposal amount that the indirect costs represents (under description). The right column would identify the total dollar amount for each broad category.

Q: Is the scope and associated work plan for this application to cover only the work that will be performed during CY2016? Or, since the rate adjustments continue in subsequent years, are we to include work in subsequent years and relate that to the ROI for those years?

A: The proposals should be specific about the CY 2016 work plan. The work plan should also include, more generally, how the work plan will flow into future years, particular if the initiative is to be expanded or altered in the future.

Q: Can HSCRC expand on the expectation for "enhanced GBR reporting"? Does that mean that each hospital will report individually on the activities of the RP or will there be some reporting requirements for the RPs? If there are any additional reporting requirements for the RPs, please outline what those are.

A: The regional planning (RP) grant report is a separate report from the GBR. The Regional Planning Grantees are required to report on their plan on December 1. No other reports are required after that for the Regional Planning Grantees. All hospitals will be submitting GBR reports annually which will provide an overview of how hospitals have utilized their infrastructure support provided in rates. The GBR report will likely be enhance for Implementation Grant Awardees so that we may track use of the awards and monitor outcomes and impacts.

Q: Where did the 15% number come from in Table 3 and the following template?

A: The 15% was an example of an expected savings. Proposals should include an expected percentage savings amount that is justified in the application. If the expected savings do not come to fruition, the Commission reserves the right to make adjustments to the permanent amount in rates in the future.

Q: Appendix B states that financial rewards to providers such as pay-for-performance incentives are not covered. Can HSCRC explain how this reconciles with the expectation to align with other providers?

A: Awards may not be used for provider incentive programs. If a hospital wishes to utilize provider incentives, it may use ROI resulting from this initiative or other related initiatives to support such programs provided that the incentive program meets all requirements of State and Federal Law or any applicable waivers. The Commission is currently working to see if waivers are attainable from applicable laws that are barriers to such incentive programs. If such waivers are obtained, the Commission and MHA will notify the hospital industry.

Q: Please clarify the instructions to "complete the summary table delineating differences by intervention for each category." If several interventions are planned, should the table be completed for each intervention or should all the interventions be summarized into a single the table?

A: All interventions should be summarized in a single table. If there are 5 interventions, for example, please number each initiative in each box – 1., 2., 3., etc. Item #1 in each box would refer to the same initiative. This is meant as a very succinct summary of the narrative.

Q: Could HSCRC provide more language to any expectations of these partnerships as it relates to the implementation awards?

A: Additional language has been added. The list of areas of focus on page 3 of the initial draft provides detail on expectations.

Q: The application deadline is listed for December 1, 2015. Given the many other deliverables due December 1st (e.g. 3 year strategic plan and the plan related to the regional partnerships) and the Thanksgiving Holiday occurring immediately before, can the HSCRC consider pushing this timeline back?

A: Due to the Thanksgiving Holiday occurring immediately before, the application deadline has been moved to December 7th, 2015.

Q: Within the Eligibility Criteria section it states "Applications that include a broad and meaningful network will receive additional points when scored". Can HSCRC be more specific as to how many additional points will be given?

A: Points will be awarded in the context of how well the model will meet the goals of the All-Payer model and to the extent to which it will elicit improvement on the metrics in Tables 1 and 2. In order to achieve this goal a meaningful set of partners would be needed. The review committee will determine how many points it will award for item #6 under the narrative section.

Q: Within the Eligibility Criteria section it states "The State reserves the right to make awards based on applications received and will determine how funds are dispersed". Can HSCRC clarify what this means; is there an additional process in addition to what is described in the RFP?

A: This clarifies that the amount awarded by the Commission is the final amount and not subject to further review or appeal. It is possible, after review, a hospital would receive multiple award amounts that would exceed the award limitation outlined in the RFP. The State would reserve the right to have a conversation with the applicant and to work out changes to proposals to bring a hospital or hospitals in compliance with the limitation. This verbiage also clarifies that the Commission may either deny funding an application, or suggest a reduction in the proposed amount or scope of a proposal.

Q: The page limit for the application is 20 pages. Can appendices be used and if so will they count towards the total page count?

A: Yes, judicious use of appendices is permitted and will not count toward the page limitation.

Q: HSCRC is using a variable savings percentage of 50%. JHHS believes that the number could vary depending on the type of patient. Some types of cases have much higher variable cost factors than others. The variable savings percentage should be based on actual data and not assumed to be 50%.

A: The Commission's variable cost factor policy is 50% meaning that hospital utilization reductions could reasonably expect to "free up" 50% in the short run with the remaining be fixed costs. However, those fixed costs could be eliminated overtime as well. When addressing total cost of care savings, a different percentage may be calculated and justified, so customized variable cost factors may be used in the template.

Q: With regards to the ROI calculation, is HSCRC only looking at hospital charges/cost or is it total cost of care?

A: Since the investment is primarily supported through hospital rates the HSCRC is most interested in the hospital ROI. However, in addition it is important to show any total cost of care savings from the initiative. Under the agreement with CMMI, the current All-Payer Model will be transitioning to a total cost of care. The HSCRC will be interested to understand how an applicant's initiative might progress

toward this transition. So hospital ROI is required in the template. However, if a total cost of care ROI can is justifiable, then the review committee will likely find this of particular interest.

Q: If a region develops a regional partnership that several hospitals are participating in, should a single response be submitted by all the participating hospitals or should all the hospitals participating in the regional partnership project submit the identical proposal?

A: The participating hospitals should submit one proposal. It should be determined however whether the funding should be provided through one of the hospital's rates, several of the hospital's rates, or all of the participating hospital's rates. A hospital may be a partner without being the "lead" hospital from which the rates will be accessed.

Q: Does a project need a defined lifespan? Be for a minimum amount of time?

A: It is expected that a project positively impact the key metrics identified in the RFP over a longer term period of time. With the eventual transition of the New All-Payer Model to a total cost of care model, an approved initiative, model, or program will be expected to continue to improve quality of care into the future and have a greater focus on reducing costs on a total cost of care basis. So while expenditures are expected to be made in CY 2016, the program should be multi-year with a greater future focus on total cost of care savings.

Q: Clarify the .75% combined grant limit

A: No single award may award increase rates of a hospital by more than 0.5% of the individual hospital's FY 2015 net patient revenue plus markup. However, if a hospital is involved in other successful awards as a lead applicant, the cumulative maximum that may be placed in that hospital's rates is 0.75% of the hospital's FY 2015 net patient revenue plus markup.